



Massachusetts Department of Public Health
Office of Emergency Medical Services
Part E: Vehicle Certification



Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances. (Make as many copies of this form as needed).

1) Service Number 	2) Service Expiration Date	3) Is this vehicle a(n) ____ Addition ____ Replacement ____ Renewal
4) SERVICE INFORMATION		
Service Name		
Service Address		
Service City	Service State	Service Zip
Business Phone Number ()	Business Fax Number ()	
Vehicle Location Address (if <u>not</u> Garaged at Service Address)		
Vehicle Location City	Vehicle Location State	Vehicle Location Zip

4) Has this vehicle been previously certified to another service in Massachusetts? ☐ YES ☐ NO

6) Vehicle Identification Number

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7) License Plate Number _____ Vehicle Garaged at _____

8) Vehicle Unit ID unique to your serviced _____ Replacement for Vehicle # _____

9) Chassis Make (Manufacturer)	Model	Year
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10) Has this chassis been replaced? ☐ YES ☐ NO

11) Ambulance Manufacturer	Model	Year
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12) Current total mileage _____

13) Class for which Ambulance is to be certified: (check one class and one type)							
<input type="checkbox"/> Class I	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	<input type="checkbox"/> Type III	<input type="checkbox"/> Class IV	<input type="checkbox"/> Fixed Wing	<input type="checkbox"/> Rotary Wing	
<input type="checkbox"/> Class II	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	<input type="checkbox"/> Type III	<input type="checkbox"/> Class V	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	<input type="checkbox"/> Type III

14A) Have waivers been issued for this? ☐ YES ☐ NO

If yes, please detail. Add extra sheets if necessary: _____

14B) This vehicle conforms to all applicable standards? ☐ YES ☐ NO

15) Has this vehicle been involved in a reportable accident since last inspection? ☐ YES ☐ NO
If yes, has the report(s) been filed with OEMS? If no, please attach report(s) ☐ YES ☐ NO

16A) What type of radio is used for ambulance-to-dispatch communications? <input type="checkbox"/> UHF <input type="checkbox"/> VHF (HEAR Network) <input type="checkbox"/> Other _____
16B) List all accessible ambulance-to-dispatch radio frequencies: _____ _____ _____ _____ _____

17A) What type of radio is used for ambulance-to-hospital communications?
☐ UHF ☐ VHF (HEAR Network) ☐ Other _____
17B) List all accessible ambulance-to-hospital radio frequencies:

18) Verify the weight of each replacement or additional ambulance. If a service is requesting certification for multiple vehicles that have the same year of manufacture, design and construction specifications, a service need only take weight verification information on one sample vehicle from the group once during the chassis-manufacturing year and copy that information onto Part E, number 18 for the other identical vehicles in the group. For example, if a service is to purchase two or more identical ambulances manufactured in 1996, verify weight of one and put that information onto Part E, number 18 for other identical 1996 vehicles.

Complete the following checklist to verify the weight of stocked ambulance:

1. Stock ambulance with required medical and vehicle equipment and supplies. ()
2. Stock ambulance with optional medical and vehicle equipment and supplies. ()
3. Stock ambulance as an in-service vehicle, with standard equipment required by the service for day-to-day operations. ()
4. Fill fuel tank(s) to full level. ()
5. Weigh stocked ambulance empty of personnel. ()
6. Record weight of ambulance Wt = _____ ()
7. Record gross vehicle weight (GVW). GVW = _____ ()
8. **Attach vehicle weight bill to this form.** ()

Note: If an ambulance is found to exceed its identified GVW rating, the service must take measures to reduce the weight in order to conform to the vehicle's posted GVW rating. Certification of an ambulance will be contingent on the licensee's ability to demonstrate compliance with the ambulance's GVW.

Authorized Signature _____ Date _____

Print Name _____ Title _____

FEE INFORMATION:

The fee for certification is \$200.00 per vehicle.

Make check(s) payable to the **Commonwealth of Massachusetts.**

Return completed **Part E Form**, **Vehicle Weight Bill**, and **Certification Fee** to:

**Office of Emergency Medical Services
2 Boylston Street, 3rd Floor
Boston, MA 02116**

OEMS use only	Fee Received	Amount	Certificate Number	Temp Certificate issued:
Wt _____ + 700 = _____ Wt Exceeds GVW Yes _____ No _____				
OEMS Review by _____				
Date _____				